Use this checklist to determine if a patient meets the restrictions for funding in the **hospital setting**. For more details, refer to Section H of the Pharmaceutical Schedule. For community funding, see the Special Authority Criteria.

**PRESCRIBER**

Name: .....

Ward: .....

**PATIENT:**

Name: .....

NHI: .....

## Human papillomavirus (6, 11, 16, 18, 31, 33, 45, 52 and 58) vaccine [HPV]

**INITIATION – Children aged 14 years and under**
Re-assessment required after 2 doses
**Prerequisites** (tick box where appropriate)

- ○ Children aged 14 years and under

**INITIATION – other conditions**
**Prerequisites** (tick boxes where appropriate)

- ○ Up to 3 doses for people aged 15 to 26 years inclusive

**or**

- ○ People aged 9 to 26 years inclusive

**and**

- ○ Up to 3 doses for confirmed HIV infection

**or**

- ○ Up to 3 doses people with a transplant (including stem cell)

**or**

- ○ Up to 4 doses for Post chemotherapy

**INITIATION – Recurrent Respiratory Papillomatosis**
**Prerequisites** (tick boxes where appropriate)

- ○ Maximum of two doses for children aged 14 years and under

**or**

- ○ Maximum of three doses for people aged 15 years and over

**and**

- ○ The person has recurrent respiratory papillomatosis

**and**

- ○ The person has not previously had an HPV vaccine



I confirm that the above details are correct:

Signed: ..... Date: .....